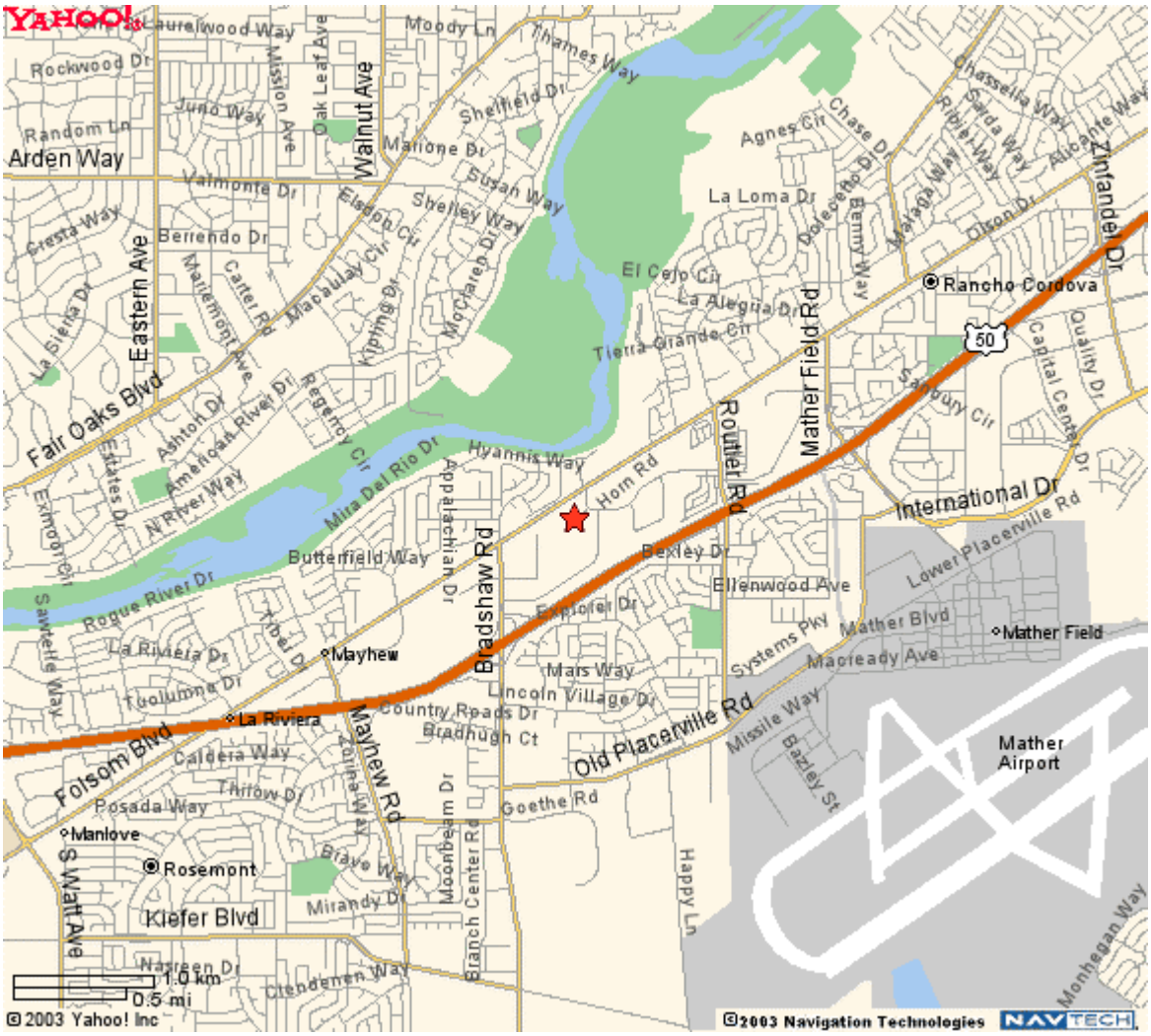
Appendix 1
Driving & Parking Instructions to the Department of Health Services

Office of Medi-Cal Procurement
9800 Old Winery Place
Sacramento, CA 95827



From the West: Take US 50 East. Exit Bradshaw Road and turn left. Turn right on Folsom Boulevard and continue east. Turn right on Horn Road and then turn right on Old Winery Place. Continue on Old Winery Place till the end of the cul-de-sac and enter the last driveway on the left. 9800 Old Winery Place is the building in the back.

From the East: Take US 50 West. Exit Bradshaw Road and turn right. Turn right on Folsom Boulevard and continue east. Turn right on Horn Road and then turn right on Old Winery Place. Continue on Old Winery Place till the end of the cul-de-sac and enter the last driveway on the left. 9800 Old Winery Place is the building in the back.

Free parking is available in the lot.

Appendix A. PAHP, PIHP and MCO Contracts
Financial Review Documentation for At-risk Capitated Contracts Ratesetting
Edit Date: 6/5/03

State: _____
Contract Period: _____
Contractor:_____
(Put "model" if same for all)

Type of Program:
___ 1915(a)(1)(A) voluntary
___ State Plan Amendment
___ 1915(b) waiver
___ 1115 waiver
___ Other ___

Type of Entity:
___ MCO
___ HIO
___ PIHP
___ PAHP

Type of Review:
____ Initial
____ Renewal
____ Amendment
____ Rates Only

Reviewer: _____ Date: _____

Rate Checklist Instructions: This checklist is a tool for Regional Offices for use in approving rates under 42 CFR 438.6(c) for all capitated Medicaid managed care programs [1915(a)(1)(A), 1915(b), 1932(a), and 1115] excluding PACE capitated programs. PACE capitated programs are still subject to Upper Payment Limit requirements under 42 CFR 460. 182. The PACE specific checklist should be used to approve PACE program rates. The non-risk checklist in Appendix C of the contract checklist should be used to approve capitated rates that are not at-risk per the definition in 42 CFR 438.6(c)(2)(ii). This checklist does not replace cost-effectiveness tests for 1915(b) waivers and budget neutrality for 1115 demonstrations. Some items only apply if the State has included a particular population, adjustment, program or policy for the managed care program. For example, if the State includes dual eligibles in its managed care program, the State **must** follow the regulations and statues outlined in item AA.1.4. Additional guidance for Regional Office review of risk-adjusted rates is forthcoming in an attachment to this appendix.

Item #	Legal Cite	Subject	Where Located	Met or NA	Comments
Appendix AA – Contract Ratesetting					
Subsection AA.1 – Overview of ratesetting methodology					
AA.1.0	42 CFR 438. 6(c)(2)(ii) 42 CFR 438.806	<u>Overview of ratesetting methodology (All portions of subsection AA.1, if applicable, are mandatory)</u> -- Please include a lay person's description of the general steps the State followed to set rates. Please specify the time period for which the rates will be effective. The time period specified should be a defined time period in the future. Rate Development or Update __ The State is developing a new rate (RO completes steps AA.1 - AA.9). __ The State is adjusting previously approved rates. (RO completes all of step AA.1 then skips to step AA.10)	Contract		

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		Note: The first option is referred to as "rebasing" the rates. Rebasing means the update/creation of new rates with new base year data that the actuary has analyzed. If a state is updating rates, the State is taking the base year data used previously and applying trend rates without creating a base year of more recent or different data.			
AA.1.1	42 CFR 438.6(c)(1)(i)(A) and (C) 42 CFR 438.6(2)(ii) 42 CFR 438.6(c)(3) 42 CFR 438.6(c)(4)(i) SMM 2089.2 FR 6/14/02 p41002-41003	Actuarial certification -The State must submit a certification, as meeting the requirements of the regulation, by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board. *Note: An Actuary who is a member of the American Academy of Actuaries will sign his name followed by the designation M.A.A.A., meaning a Member of the American Academy of Actuaries. For further information see* www.actuary.org/faqs.htm The certification must include a detailed description of the ratesetting methodology employed by the State as outlined in this checklist and document compliance with generally accepted actuarial principles and practices. The description should be detailed and include assurances and enough explanation for the RO to determine the State's compliance with CMS policy. The RO should use that detailed description to verify compliance with managed care regulations. *Note: Actuaries can create either rates or rate ranges so long as the methodology (including all assumptions) to get to the actual rates in the contract are specified and meet CMS requirements. When developing rate ranges, there are a few principles to keep in mind. For instance, developing an actuarially sound rate and then adding plus or minus a given percentage is arbitrary without an underlying method such as confidence intervals determining what the given percentage should be. CMS prefers that actuaries specifically price the lower and upper bound of a range in a similar fashion to pricing a single rate. For example, the lower bound may represent an amount commensurate with what a very efficient MCO with particular utilization assumptions could achieve without denying medically necessary services. The upper bound may represent the least amount of efficiency a state is willing to purchase. Given these definitions, the actuary can then price these upper and lower data points with assumptions tailored for each. The actuary would need to submit all assumptions to CMS if certifying a rate range. The final rate assumptions would also need to be submitted once a final rate is arrived at. This methodology is consistent for both*	Contract or Ratesetting Documentation		

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		medical and administrative costs. This method is also very intuitive and conducive to competitive bids and negotiations. If there are instances where actuaries believe that information their State is required to submit would represent trade secrets or proprietary information, as described in the Freedom of Information Act (FOIA) (5 U.S.C. 552(a)), the information should be identified as such and may be withheld from public disclosure under the provisions of the FOIA.			
AA.1.2	45 CFR 74.43 42 CFR 438.6(a) 42 CFR 438.806(a) and (b)	<u>Procurement, Prior Approval and Ratesetting</u> - ___ Option 1: Open cooperative contracting --Open cooperative contracting occurs when the State signs a contract with any entity meeting the technical programmatic requirements of the State and willing to be reimbursed the actuarially-sound, State-determined rate. *Note: The actuarial soundness of the rate methodology under sole source contracting where the state contracts with a single entity to provide a set of services must be documented as meeting the requirements of 42 CFR 438.6(c) under this option. The contract must meet the procurement requirements in 45 CFR Part 74. See Appendix B. Note: earlier versions of this checklist erroneously referred to a budget percentage factor applied to a set of rates determined in an actuarially sound manner. If a single rate is set by the actuary and determined actuarially sound, the State should not apply a budget percentage factor to that rate.* ___ Option 2: Competitive Procurement -- A range of percentage factors are applied to the rates (i.e., the rates are developed using a set of assumptions meeting federal regulations that results in a range of acceptable bids to determine a bid range for rates). A State could also disclose a maximum or minimum acceptable payment and encourage bids below or above that amount. *Note: the entities' bids should include documentation and a description of how the resulting contract rates are determined in sufficient detail to address this set of regulatory criteria for each contract. Competitive procurement occurs when entities submit bids and the State negotiates rates within the range of acceptable bids. In a 1915(b) waiver, the savings must be large enough to allow the State to fund the State's operation of the program. The State should document an analysis of the accepted rates that includes aspects of this rate checklist (Steps AA.2-AA.9). The RO should check to see that the State's rationale for choosing the specific bid range is*	Contract or Ratesetting Documentation		

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		noted and reasonable.			
AA.1.3	42 CFR 438.6(c)(1)(i)(B)	Population Biased Selection Adjustment (Mandatory for programs with Voluntary Enrollment) – Rates for voluntary programs must be analyzed and adjusted to ensure that they are appropriate for the populations to be covered if a healthier or sicker population voluntarily chooses to enroll (compared to the population data on which the rates are set). *Note: this analysis is needed when beneficiaries are mandatorily enrolled in managed care but have a choice between a fee-for-service program and a capitated program (e.g., PCCM and MCO).* Voluntary rates were set using one of the two techniques described in 1.2. An adjustment - making the data actuarially equivalent to the enrolled population - accounts for the effect of biased selection and minimizes the selection bias effect on the voluntary program. This adjustment is also made in risk-adjusted rates where there is a single plan with voluntary enrollment. With the renewal of each 1915(a)(1)(A) voluntary contract, the State must submit an analysis of biased selection to the RO to validate the accuracy of this calculation in prior contract periods because these programs are not required to submit waiver cost-effectiveness. That analysis must document the biased selection assumptions made in previous contracts, the actual experience of the State with enrollment patterns and utilization under the contract, and the State's new proposed biased selection factor for the upcoming contract based upon actual experience. Services provided by the managed care plan that exceed the services covered in the Medicaid fee-for-service program (i.e., the Medicaid State Plan) may not be used to set capitated Medicaid managed care rates. *Note: The actuary should examine current period population characteristics for the population voluntarily selecting to enroll in the program versus the characteristics of the population opting to remain outside of the program. The question is whether or not the population enrolled in the voluntary program is actuarially equivalent to the population choosing not to be enrolled in the program. If the populations are different, then the actuary should ensure that capitation rates reflect these differences.* *Note: The selection factor is required for any program to ensure that selection bias was measured and used if appropriate. States are requested to document the level of selection bias expected or occurring between the enrolled population and*	Contract or Ratesetting Documentation		

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		the eligible but non-enrolled population and use that information to ensure that the data used to set rates was appropriate for the population.			
AA.1.4	1905(p) (1-3) SMM 3490 (ff) SMD letter 9/30/00 6/30/00 Policy Memorandum	Dual Eligibles (DE) (Mandatory for programs enrolling DE) –Some States include capitation payments for DE. Payment limits for DE are outlined in Medicaid fee-for-service law and regulation. Because the statute and CMS policy specifies that the State may only pay for Medicaid-eligible individuals, those Medicaid payment limits must be observed. Only the following groups of DE are entitled to Medicaid Services. If they are included in a capitated managed care contract, they should have a Medicaid rate calculated separately from other DE: ■ QMB Plus ■ Medicaid (Non QMB and Non SLMB) ■ SLMB Plus Eligibles and services for beneficiaries in the other five DE categories (QMB-only, QDWI, SLMB-only, QI1, and QI2) should be specifically excluded from the capitated rates calculated for the 3 DE categories above (QMB Plus, Medicaid (Non QMB and Non-SLMB), and SLMB Plus). Most states choose to exclude all other categories of DE from Medicaid managed care. If DE beneficiaries in the following five categories are allowed to choose to enroll in capitated managed care, the Medicaid State Agency would continue to be liable for the same Medicare payments (e.g., Medicare premiums) as under FFS. *Note: Medicare premiums in the above section refer to the Medicare fee-for-service premiums that beneficiaries are liable for to be eligible for Medicare fee-for-service.* The beneficiary would be liable for any Medicaid services payment because they are not eligible for Medicaid services: ■ QMB-only ■ QDWI ■ SLMB-only ■ QI1 ■ QI2 If the M+C organization charges monthly premiums, the premiums generally cover the basic package of Medicare covered benefits, but may include additional			

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		premium amounts for supplemental benefits, which are not otherwise covered under Medicare. Medicaid is liable for payment of monthly M+C premium amounts for QMB categories (QMB-only and QMB Plus) for the basic packages of Medicare covered benefits only, if so elected in the Medicaid State plan (State Plan preprint page 29, 3.2(a)(1)(i)). Medicaid is also liable for Medicare cost-sharing expenses (deductibles, coinsurance and copayments) for Medicare covered services to the payment amount specified in the Medicaid State plan (Supplement 1 to Attachment 4.19-B). When a M+C organization imposes cost-sharing charges in addition to premiums for Medicare-covered services on their enrollees, the Medicaid agency must pay those costs for QMBs regardless of whether the State elected to include premiums in cost-sharing. No Medicaid services or payments would be included in the payment calculated for the entity. *Note: the reference to premiums paid to Medicare+Choice (M+C) organizations are only in relationship to QMB beneficiaries.*			
AA.1.5	42 CFR 435.1002(b) 1903(f)(2)(A) SMM 3645	Spenddown – FFP is not available for expenses that are the recipient's liability for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income. Spenddown is the amount of money that an individual with income over Medicaid eligibility limits must spend on medical expenses prior to gaining Medicaid eligibility. The spenddown amount is equal to the dollar amount the individual's income is over the Medicaid income limit. 42 CFR 435 Subpart D. States have two methods for calculating spenddown. Regardless of the option selected by the State, the capitated rates must be calculated without including expenses that are the recipient's liability. 1. Regular method – The individual client collects documentation verifying that a medical expense has occurred and submits to the State. States must ensure that capitation rates for individuals with spenddown (both medically needy beneficiaries and beneficiaries in 209(b) States with spenddown amounts) are calculated without including expenses that are the recipient's liability. 2. Pay-in method – The individual client pays a monthly installment payment or lump sum payment to the State equal to the spenddown amount rather than collecting documentation on medical expenses and submitting that documentation to the case worker. The same income and resource standards apply as in the regular method. The State then tracks the client's medical	Contract or Ratesetting documentation		

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		costs to ensure that the costs exceed the spendown amount. Here the State sets capitation rates to include expenses that are of the recipient's liability and must ensure that the federal government receives its share of the monthly or lump sum payment from the client.			
AA.1.6	42 CFR 438.6(c)(2)(ii) SMM 2089.2, 2092.8	Payments under risk contracts – The contract must specify the payment rates and any risk-sharing mechanisms, and the actuarial basis for computation of those rates and mechanisms (See also Steps AA.6 and AA.10)	Contract		Duplicate with Step AA.6 & AA.10
AA.1.7	42 CFR 447.15 42 CFR 438.2 42 CFR 438.812(a)	Risk contracts – The entity assumes risk for the cost of services covered under the contract and incurs loss if the cost of furnishing the services exceed the payments under the contract. The entity must accept as payment in full, the amount paid by the State plus any cost sharing from the members. Payments for carrying out contract provisions including incentive payments are medical assistance costs.	State Regulation or Contract		
AA.1.8	42 CFR 438.60	Limit on payment to other providers - The State agency must ensure that no payment is made to a provider other than the entity for services available under the contract between the State and the entity, except when these payments are provided for in title XIX of the Act, in 42 CFR, or when the State agency has adjusted the capitation rates paid under the contract to make payments for graduate medical education. *Note: see Step AA.3.8 for GME adjustments.*	Contract or Ratesetting Documentation		
Subsection AA.2 – Base Year Utilization and Cost Data					
AA.2.0	42 CFR 438.6(c)(3)(i) 42 CFR 438.6(c)(1)(i)(B) FR 6/14/02 p41000	Base Year Utilization and Cost Data (All portions of subsection AA.2, if applicable, are mandatory) - Data is derived from the Medicaid population, or if not, is adjusted to make it comparable to the Medicaid population. The base data used were recent and are free from material omission. Samples of databases and estimates of utilization are not acceptable bases for setting rates. There should be, at a minimum, one year of data. In addition, data should not be older than 5 years unless it can be reasonably justified. Base data and utilization and cost assumptions are defined and relevant to the Medicaid population (i.e., the database is appropriate for setting rates for the given Medicaid population). Examples of acceptable databases on which to base utilization assumptions are: Medicaid FFS databases, Medicaid managed care encounter data, State employees health insurance databases, low-income health insurance program databases. States without recent FFS history and no validated encounter data will need to	Contract or Ratesetting Documentation		

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		develop other data sources for this purpose. States and their actuaries will have to decide which source of data to use for this purpose, based on which source is determined to have the have the highest degree of reliability, subject to RO approval. The data (including encounter data and data external to Medicaid) was validated by the State and documentation of that validation was included. The validation method should relate to the actual source of the data: • Medicaid FFS data: 1) SURS review or equivalent Fraud and Abuse review and 2) MMIS edits process; • Medicaid encounter data: 1) Medical record audit or other encounter data audit and 2) Encounter data electronic edits process; • Private Sector data: 1) Medical record audit or other encounter data audit and 2) Encounter data and electronic edits process. The base data should be included for CMS review with a description of how the State and its actuary researched and determined what to do with "dirty" data not fitting previously assigned categories of service, age, gender, region, and eligibility category. *Note: an example of this would include males delivering newborns or having hysterectomies, nursery costs for adults, other service costs, etc.* *Note: The CMS RO should determine the years for which the data was collected. Incomplete data because of claims submission lags should be adjusted in 3.14. Other reasons for incomplete data should be analyzed by the RO and approved only if the data can result in reasonable and predictable rates. The CMS RO should receive a copy of the State/actuary's data book, which includes base data used in the ratesetting methodology. Data books are typically provided to entities during competitive bid situations.* *Note: The CMS RO may approve other sources not listed here based upon the reasonableness of the given data source. In addition, some states have implemented reporting requirements of the health plans to be used as an* ***supplementary*** *data source that would improve on some of the shortcomings of these other specific databases (e.g., some actuaries now require the submission of financial reports. Financial report should supplement but not replace base*			

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		utilization and cost data). The overall intent of these reporting requirements is to collect the same information that is available in the encounter data, but in a more complete and accurate reflection of the true cost of services. *Note: The CMS RO may approve other validation methods not listed here based upon the reasonableness of the State's approach for the given data source.* *Note: Once the base period is established, the State should review the base period data tables with the actuary to discuss "dirty" data, assumptions, etc. The State is ultimately responsible for all policy decisions made by the actuary. The documentation should acknowledge this review and the State's confirmation of the analysis.*			
AA.2.1	42 CFR 438.6(c)(3)(i) FR 6/14/02 p41002 & 40998	Utilization and Service Cost Base Year Data Utilization data is appropriate to the Medicaid population and the base data was reviewed by the State for similarity with the covered Medicaid population. That is, if the utilization assumptions are not derived from recent Medicaid experience, the State should explain and document the source of assumptions and why the assumptions are appropriate to the Medicaid population covered by these proposed rates. Service cost assumptions are appropriate for a Medicaid program and the base data was reviewed by the State for similarity with the Medicaid program's current costs. *Note: except in the case of payments to FQHCs that subcontract with entities, which are governed by section 1903(m)(2)(A)(ix), CMS does not regulate the payment rates between entities and subcontracting providers. Payment rates are adequate to the extent that the capitated entity has documented the adequacy of its network.* The term "appropriate" means specific to the population for which the payment rate is intended. This requirement applies to individuals who have health care costs that are much higher than the average. Appropriate for the populations covered means that the rates are based upon specific populations, by eligibility category, age, gender, locality, and other distinctions decided by the State. Appropriate to the services to be covered means that the rates must be based upon the State plan services to be provided under the contract. There is no stated or implied requirement that entities be reimbursed the full cost of care at billed	Contract or Ratesetting Documentation		

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		charges. *Note: for example, individuals in the database roughly utilize services in the same amount as a Medicaid population and the costs of services are roughly similar to the State's current Medicaid service costs. A high cost/utilization private pay health employee database comprised of primarily adult males in high paying jobs would be a suspect database for comparison to Medicaid managed care.* *Note: Estimates and samples of data are not acceptable. CMS prefers that base year costs by service category separate the data with respect to unit cost and utilization data, however it is not required.*			
AA.2.2	42 CFR 438.6(c)(4)(ii)(B)	Medicaid Eligibles under the Contract – Data for individuals in the base period who would not be eligible for managed care contract services were separated and left out of the data from contract eligibles. The State may apply an appropriate adjustment factor to the data to remove these ineligibles if sufficient documentation is presented. An explanation of the Medicaid eligibility categories was defined for the actuary. The state and actuary have a table listing their agreement on how eligibility categories are defined and what population characteristics the eligibility categories have. The explanation and documentation should list the eligibility categories specifically included and excluded from the analysis. *Note: for example, if mentally retarded individuals are not in the managed care program, utilization, eligibility and cost data for mentally retarded eligibles should all be excluded from the rates.* *Note: all references in this checklist to Medicaid eligibles include 1115 expansion populations approved under 1115 demonstration projects.*	Contract or Ratesetting Documentation		
AA.2.3	42 CFR 438.6(c)(4)(ii)(A) FR 6/14/02 p40998, 4999, 41000, 41001, 41003, & 41005	State Plan Services only (no 1915(b)(3) or 1115 (a)(2) services) - The State must document that rates are based only on State Plan approved services. Service costs that are not in the managed care contract were separated from State Plan approved services capitated under the Medicaid managed care contract. The explanation should list the service costs in the database specifically excluded from the analysis. Categories of Medicaid services need to be defined for the actuary in a manner that will allow the actuary to compare services in the base data to State Plan Approved services capitated under the Medicaid managed care contract. Services provided by the managed care plan that exceed the services covered in the Medicaid fee-for-service program (i.e., the Medicaid State Plan) may not be used to set capitated Medicaid managed care rates. • States using entity **encounter data** may base utilization and service costs on	Contract or Ratesetting Documentation		

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		non-FFS data. However, actuaries must adjust the data to reflect FFS State plan services only. • **Services not part of the State plan** that are unilaterally contractually required or "suggested" (typically authorized as "1915(b)(3) and 1115(a)(2) services") may not be used to calculate actuarially sound rates. • **1915(b)(3) or 1115(a)(2) services** must be paid out of separate payment rates. 1915(b)(3) services and administration costs for those services must be financed out of separate payments approved prospectively through the 1915(b) waiver process. 1115(a)(2) services must be financed out of separate payments approved through the 1115 demonstration budget neutrality agreement. *Note: 1915(b)(3) services and 1115(a)(2) services may not be used to set rates. 1915(b)(3) services and administration costs for those services must be financed out of separate payments approved prospectively through the 1915(b) waiver process. 1115(a)(2) services must be financed out of separate payments approved through the 1115 demonstration budget neutrality agreement.* • **EPSDT extended/supplemental services** for children are considered State Plan Approved services and may be built into the capitated rates. • **HCBS waiver services** may only be included for capitated contracts under 1915(b)/(c) concurrent waiver or in CMS RO approved 1915(a)(1)(A)/(c) capitated contracts. *Note: for the purposes of pre-PACE under 1915(a)(1)(A) HCBS services should be included. If the population is a nursing home-certifiable population and eligible for HCBS, the State may consider HCBS as an acceptable service for long-term care managed care.* • **1915(a)(1)(A) capitated rates** must be based on State Plan Approved services and 1915(c) approved services only. *Any additional services must be paid for by the plan out of capitated rate savings. See Step AA.2.4 of this checklist and 42 CFR 438.6(e).* *Note: The inclusion of any additional Medicaid services during the term of a contract could either be handled through a contract amendment or a contract term that provides for the contingency, subject to CMS approval. Amendments must be prior approved by the CMS RO. See Step AA.10.*			
AA.2.4	438.6(e) FR 6/14/02 p 41003	<u>Services that may be covered by a capitated entity out of contract savings</u> - An entity may provide services to enrollees that are in addition to those covered under the State plan, although the cost of these services cannot be included when	Contract		

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		determining the payment rates. When a State agency decides to contract with an entity, it is arranging to have some or all of its State plan services provided to its Medicaid population through that entity. The State has not modified the services that are covered under its State plan, nor is it continuing to pay, on a FFS basis, for each and every service to be provided by the entity. Further, entities have the ability to provide services that are in the place of, or in addition to, the services covered under the State plan, in the most efficient manner that meets the needs of the individual enrollee. These additional or alternative services do not affect the capitation rate paid to the entity by the State. The capitation rates should not be developed on the basis of these services. The State determines the scope of State plan benefits to be covered under the managed care contract, and sets payment rates based on those services. This does not affect the entities right, however, to use these payments to provide alternative services to enrollees that would not be available under the State plan to beneficiaries not enrolled in the entity. • The additional services allowed under §438.6(e) are not included in the calculation of capitation payments. These services may only be offered by an entity paid on a risk basis. This is because these entities would typically use "savings" (a portion of the risk payment not needed to cover State plan services) to cover the additional services in question. *Note: for example, an MCO may provide Lamaze classes to pregnant beneficiaries even though this is not a contract requirement or State Plan approved Medicaid service*. • Additional services may also be provided for under section 1915(b)(3) or 1115 (a)(2) waiver authority that allows a State to share savings resulting from the use of more cost-effective medical care with beneficiaries by providing them with additional services. *For example, a substance abuse capitated program providing care under the ASAM clinical criteria may provide halfway house services to enrollees using 1915(b)(3) or 1115(a)(2) services. See 2.3 for additional information regarding this authority.* In either case these services are additions to State plan services and are paid for by plans or through shared savings under the waiver program. Since payment is made by the plans or through shared savings, such payments do not fall under the regulation.			
Subsection AA.3 – Adjustments to the Base Year Data					
AA.3.0	42 CFR	<u>Adjustments to the Base Year Data -</u> The following adjustments to the base period	Contract or		

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	438.6(c)(3)(ii) and (iv)	listed in 3.1 to 3.14 are made to construct rates to reflect populations and services covered during the contract period. These adjustments ensure that the rates are predictable for the covered Medicaid population. **Adjustments must be mutually exclusive and may not be taken twice. States must document the policy assumptions, size, and effect of these adjustments and demonstrate that they are not double counting the effects of each adjustment. The RO should check to ensure that the State has contract clauses (or State Plan Amendments), where appropriate, for each adjustment. If projections are used, the State should have mechanisms to measure that the adjustment size was appropriate to the extent possible and the RO should verify with each renewal or amendment that the measurement occurs and that previously made adjustments were appropriate.** Adjustments to the Base Year that may increase the Base Year: • Administration (Step AA.3.2 - Mandatory) • Benefit, Programmatic and Policy change in FFS made after the claims data tape was cut (Step AA.3.1) • Certified Match provided by public providers in FFS (Step AA.3.14 – Mandatory, if applicable) • Claims completion factors (Step AA.3.13 – Mandatory) • Cost-sharing in FFS is not in the managed care program (Step AA.3.7 – Mandatory) • FFS benefit additions occurring after the extraction of the data from the MMIS are taken into account (Step AA.3.1) • Financial Experience Adjustment (Step AA.3.14) • Medical service cost trend inflation (Step AA.3.10 - Mandatory) • One-time only adjustment for historically low utilization in FFS program of a State Plan Approved benefit (i.e., dental) (Step AA.3.11) • Patient liability for institutional care will be charged under this program (Step AA.3.12) • Payments not processed through the MMIS (Step AA.3.14) • Price increase in FFS made after the claims data tape was cut (Step AA.3.10) • Utilization due to changes in FFS utilization between the Base Year and the contract period. Changes in utilization of medical procedures over time is	Ratesetting Documentation		

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		taken into account (Step AA.3.11) Adjustments to the Base Year that may adjust the Base Year downward: • Benefit deletions in the FFS Program occurring after the extraction of the data from the MMIS are taken into account (Step AA.3.1 – Mandatory) • Cost-sharing in managed care in excess of FFS cost-sharing (Step AA.3.7) • Disproportionate Share Hospital Payments (Step AA.3.5 – Mandatory, if applicable) • Financial Experience Adjustment (Step AA.3.14) • FQHC/RHC payments (Step AA.3.9 – Mandatory) • Graduate Medical Education (Step AA.3.8 – Mandatory, if applicable) • Income Investment Factor (Step AA.3.14) • Indirect Medical Education Payments (Step AA.3.8 – Mandatory, if applicable) • Managed Care Adjustment (Step AA.3.14) • PCCM Case Management Fee (Step AA.3.14) • Pharmacy Rebates (Step AA.3.14) • Post-pay recoveries (TPL) if the State will not collect and allow the MCE to keep TPL payments (Step AA.3.6 – Mandatory, if applicable) • Recoupments not processed through the MMIS (Step AA.3.14) • Retrospective Eligibility costs (Step AA.3.4) Cost-neutral Adjustments: • Data smoothing for data distortions and individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims including risk-sharing and reinsurance (Step AA.5.0 - Mandatory) *Note: The CMS RO must review all changes for appropriateness to the data selected by the State (e.g., if the State is using encounter data, then adjustments for FFS changes may not be appropriate). Some adjustments are mandatory. They are noted as such.*			
AA.3.1	42 CFR 438.6(c)((4)(ii)(A)	Benefit Differences (Mandatory if deletions in the FFS program) - Differences in the service package for the Base Period data and the Medicaid managed care covered service package are adjusted in the rates. Documentation of assumptions and estimates is required if this adjustment is made.	Contract or Ratesetting Documentation		

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		New benefits under the State's FFS program that have been incorporated into the State Plan should be added through this adjustment. The value of these programmatic service changes should be documented. Services provided by the managed care plan that exceed the services covered in the Medicaid fee-for-service program (i.e., the Medicaid State Plan) may not be used to set capitated Medicaid managed care rates.			
AA.3.2	42 CFR 438.6(c)(4)(ii)(A) 42 CFR 438.812 FR 6/14/02 p41001 Family Planning FMAP 1903(a)(5) and 42 CFR 433.10(c)(1) Title XIX Financial Management Review Guide #20 Family Planning Services (See page 1 of this guide for a complete list of statutory and regulatory	<u>Administrative cost allowance calculations (Mandatory)</u> - Only administrative costs directly related to the provision of Medicaid State Plan approved services to Medicaid-eligible members are built into the rates. The aggregate loading for administration and profit is appropriate for the level of medical service cost and utilization assumed for the size of the population anticipated to be enrolled by a contracting entity. The assumptions for the administrative cost allowance must be documented and submitted with the rate approval package. *Note Regional Office guidance: This guidance is intended for use as a "rule of thumb" only. Contractor administrative costs (non-service cost expenditures including, but not limited to, marketing, claims processing, medical management, profit, and staff overhead) of up to 15% of the overall PMPM paid to entities may be built into the rates. Administrative costs higher than 15% (medical expenses lower than 85%) must be justified by the State and prior approved by the CMS RO. Lower and higher administrative costs can certainly be justified for an entity with high capitation rates (lower) or high start-up costs (higher). The CMS RO may challenge and not approve administrative costs either more or less than 15% of the overall PMPM paid to the entity if documentation and assumptions are not valid. 15% PMPM is the average amount built into capitation rates for commercial MCOs. For example, for a long-term care capitated program, the 15% rule of thumb may be inappropriate because the rates are so large that 15% of the PMPM is too high. Another example where the 15% PMPM may be too high would be if the plan is prohibited from marketing. Actuaries are not required to build a full 15% PMPM into the rates for administration but must include some amount for plan administration. Actuaries should address why any administration allowance in the rate is appropriate in its documentation to CMS.*	Contract or Ratesetting Documentation		

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	references) 7/3/01 SMD Letter Indian Health Service facility FMAP 1905(b) and 42 CFR 433.10(c)(2)	*This guidance is intended for use as a "rule of thumb" only. Documentation and reasonableness should guide RO review rather than absolute adherence to the 15% PMPM rule of thumb.* In order to receive Federal reimbursement, administrative costs at the entity level are subject to all applicable Medicaid administrative claiming regulations and policies. Medicaid pays for the administration of Medicaid services to Medicaid beneficiaries covered under the contract. The following examples are not all inclusive. • Public entities cannot build in administrative costs to pay for non-Medicaid administration or services such as education, prisons, or roads, bridges and stadiums using the administrative cost in capitated rates. • Administrative costs for State Plan approved services can only be claimed for services to be delivered to Medicaid beneficiaries under the contract (not for 1915(b)(3) or 1115(a)(2) services. Administration costs in contracts must be allocated to the appropriate programs (e.g. public health must pay for the administration of public health services to non-Medicaid eligibles). CMS provides FFP only for the administration of Medicaid services to Medicaid beneficiaries covered under the contract. • Regular Medicaid matching rules apply. See 42 CFR 438.812 which states that all payments under a risk contract are medical assistance costs (FMAP rate) and which requires an allocation for non-risk contracts between service costs and administrative costs. Separate administrative costs under the State Plan should not be placed under a capitated contract in order for the State to draw down the FMAP (50-80%) rate rather than the administrative rate (50%). Examples of this include administrative transportation and case management costs. Separate administrative contracts including this administration can be written for capitated entities that will be matched at 50% by the federal government. *Note: Family planning and Indian health services enhanced matching FMAP rates and rules do apply to family planning and Indian Health services in capitated contracts. For family planning, the State must document the portion of its rates that are family planning consistent with the CMS Title XIX Financial Management Review Guide #20 Family Planning Services, especially Exhibit A. Please refer to the 7/3/01 SMD letter regarding the need for timely filing of claims.* • Paperwork costs, such as time spent writing up case notes, associated with			

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		face-to-face contact with an eligible member is already included in the direct service cost and should not be built into the capitated rates again. Medicaid State agencies should also not pay separately for this administration. This occurs when an entity contracts with a public entity to provide services. The public entity provides the direct services and then bills the State Medicaid agency or the entity for administration associated with the direct services. Schools are providing the primary examples of this practice. This could also occur if an entity builds in additional administrative costs associated with direct service that have already been built into the direct service rates to providers. *Note: CMS does not have established standards for risk and profit levels but does allow reasonable amounts for risk and profit to be included in capitated rates.*			
AA.3.3	42 CFR 438.6(c)(3)(ii) and (iv)	Special populations' adjustments - Specific health needs adjustments are made to make the populations more comparable. The State may make this adjustment only if the population has changed since the utilization data tape was produced (e.g., the FFS population has significantly more high-cost refugees) or the base population is different than the current Medicaid population (e.g., the State is using the State employees health insurance data). The State should use adjustments such as these to develop rates for new populations (e.g., SCHIP eligibles or 1115 expansion eligibles). The State should document why they believe the rates are adequate for these particular new populations.	Contract or Ratesetting Documentation		
AA.3.4	42 CFR 438.6(c)(3)(ii) and (iv)	Eligibility Adjustments - The actuary analyzed the covered months in the base period to ensure that member months are parallel to the covered months for which the entities are taking risk. Adjustments are often needed to remove from the base period covered months -- and their associated claims – that are not representative of months that would be covered by an entity. For example, many newborns are retrospectively covered by FFS Medicaid at birth, and will not enroll in an entity (even in mandatory enrollment programs) until a few months after birth. Because the costs in the first months of life are very high, if retrospective eligibility periods are not removed from the base period the state could be substantially over-estimating entities' average PMPM costs in the under-1 age cohort. Similar issues exist with the mother's costs when the delivery is retrospectively covered by FFS Medicaid, and with retrospective eligibility periods in general.	Contract or Ratesetting Documentation		
AA.3.5	1923(i) BBA 4721(d)	DSH Payments (Mandatory) *[contracts signed after 7/1/97]* – DSH payments may not be included in capitation rates. The State must pay DSH directly to the DSH	Contract or Contract rate		

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		facility.	documentation		
AA.3.6	42 CFR 433 Sub D 42 CFR 447.20 SMM 2089.7	Third Party Liability (TPL) (Mandatory) – contract must specify any activities the entity must perform related to third party liability. The ratesetting documentation must address third party liability payments and whether the State or the entity will retain TPL collections. Rates must reflect the appropriate adjustment (i.e., if the entity retains TPL collections the rates should be adjusted downward or if the State collects and retains the TPL the rates should include TPL).	Contract		See Section A of the contract checklist.
AA.3.7	42 CFR 447.58 SMM 2089.8	Copayments, Coinsurance and Deductibles in capitated rates (Mandatory) – *Note: Each of these adjustments assume that FFS data (net of copayments) is used as the base data. If other data is being used, the State must document that copayments are appropriately accounted for in the rate setting process.* If the State Medicaid agency chooses to not impose the FFS cost-sharing in its pre-paid capitation contracts with entities, the State must calculate the capitated payments to the organization as if those cost sharing charges were collected. For example, if the State has a $2 copayment on FFS beneficiaries for each pharmacy prescription, but does not impose this copayment on any managed care member, the State must add back an amount to the capitated rates that would account for the lack of copayment. *Note: this would result in an addition to the capitated rates.* For 1115 expansion beneficiaries only, if the state imposes more deductibles, coinsurance, co-payments or similar charges on capitated members than the State imposes on its fee-for-service beneficiaries, the State must calculate the rates by reducing the capitation payments by the amount of the additional charges. *Note: this would result in a reduction to the capitated rates.*	Contract or Contract rate documentation		
AA.3.8	42 CFR 438.60 42 CFR 438.6(c)(5)(v) FR 6/14/02 p41005	Graduate Medical Education (GME) (Mandatory) - If a State makes GME payments directly to providers, the capitation payments should be adjusted to account for the aggregate amount of GME payments to be made on behalf of enrollees under the contract (i.e., the State should not pay the entity for any GME payments made directly to providers). States must first establish actuarially sound capitation rates prior to making adjustments for GME. CMS permits such payments only to the extent the capitation rate has been adjusted to reflect the amount of the GME payment made directly to the hospital. States making payments to providers for GME costs under an approved State plan	Contract or Contract rate documentation		

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		must adjust the actuarially sound capitation rates to account for the aggregate amount of GME payments to be made directly to hospitals on behalf of enrollees covered under the contract. These amounts cannot exceed the aggregate amount that would have been paid under the approved State plan for FFS. This prevents harm to teaching hospitals and ensures the fiscal accountability of these payments.			
AA.3.9	SMD 4/20/98 SMD 10/23/98	FQHC and RHC reimbursement (Mandatory) – The State may build in only the FFS rate schedule or an actuarially equivalent rate for services rendered by FQHCs and RHCs. The State may NOT include the FQHC/RHC encounter rate, cost-settlement, or prospective payment amounts. The entity must pay FQHCs and RHCs rates comparable to non-FQHC and RHCs. The entity cannot pay the annual cost-settlement or prospective payment.	Contract		
AA.3.10	42 CFR 438.6(c)(3)(ii) FR 6/14/02 p41000	Cost trending/Inflation (Mandatory) – Medical inflation factors are based on historical medical State-specific costs or a national/regional medical market basket applicable to the state and population. Justification for the predictability of the inflation rates is given regardless of the source. Differentiation of trend rates is documented (i.e., differences in the trend by service categories, eligibility category, etc). All trend factors and assumptions are explained and documented. *Note: This also includes price increases not accounted for in inflation (i.e., price increases in the fee-for-service or managed care programs made after the claims data tape was cut). This adjustment is made if price increases are legislated by the Legislature. The RO must ensure that the State "inflates" the rate only once and does not double count inflation and legislative price increases. The State must document that program price increases since the rates were originally set are appropriately made.*	Contract or Ratesetting Documentation		
AA.3.11	42 CFR 438.6(c)(3)(ii) and (iv) FR 6/14/02 p41003	Utilization Adjustments - Two types of Utilization adjustments are possible: utilization differences between base data and the Medicaid managed care population and changes in Medical utilization over time. • Base period differences between the underlying utilization of Medicaid FFS data and Medicaid managed care data assumptions are determined. These adjustments increase or decrease utilization to levels that have not been achieved in the base data, but are realistically attainable CMS program goals. States may pay for the amount, duration and scope of State plan services that States expect to be delivered under a managed care contract. Thus, States may adjust the capitation rate to cover services such as EPSDT or prenatal care at the rate the State wants the service to be delivered to the enrolled population.	Contract or Ratesetting Documentation		

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		The RO should check to ensure that the State has a contract clause for using mechanisms such as financial penalties if service delivery targets are not met or incentives for when targets are met. *Note:* a*n example of this adjustment is an adjustment to Medicaid FFS data for EPSDT where FFS beneficiaries have historically low EPSDT utilization rates and the managed care contract requires the entity to have a higher utilization rate. The State should have a mechanism to measure that the higher utilization occurs and the RO should verify that this measurement occurs.* • A change in utilization of medical procedures over time is taken into account. Documentation is required if this adjustment is made. The State should document 1) The assumptions made for the change in utilization. 2) How it came to the precise adjustment size. 3) That the adjustment is a unique change that could not be reflected in the utilization database because it occurred after the base year utilization data tape was cut. Examples may include: major technological advances (e.g., new high cost services) that cannot be predicted in base year data (protease inhibitors would be acceptable, a new type of aspirin would not be acceptable). *Note: These adjustments can be distinguished from each other. The first is utilization change stemming from historic under- or over-utilization that is being corrected solely by the implementation of this program. Historic access problems in FFS Medicaid programs may be addressed through this adjustment. The second is a one time only non-recurring adjustment because of a unique utilization change projected to occur (or which did occur) after the base year data tape was produced.*			
AA.3.12	42 CFR 435.725 (Categorically Needy) 42 CFR 435.832 (Medically Needy)	<u>Post-Eligibility Treatment of Income (PETI)</u> *(This applies for NF, HCBS, ICF-MR, and PACE beneficiaries in capitated programs where PETI applies only.)* - If the MC program waiver or SPA requires that the State consider post-eligibility treatment of income, the State pays the capitated rate for that member less the client participation amount. The State should calculate the client participation amount specifically for each member using the FFS methodology. Patient liability is a post-eligibility determination of the amount an institutionalized Medicaid beneficiary is liable for the cost of their care. It is also called client participation, cost of care, PE, and post-eligibility treatment of	Contract or Ratesetting Documentation		

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		income. 42 CFR 435 Subpart H If the MMIS data tape is cut to reflect only the amount the Medicaid agency paid providers, then patient liability for cost of care must be added back to the rate to determine the total cost of care for an individual. The actual rate paid to the capitated entity would be the rate for the member minus any patient liability for that specific enrolled member. The capitated entity would then need to collect the patient liability from the enrolled member. Client participation should not be used to reduce total costs for all participants. Client participation should be assessed individually, reducing the individual rate paid to the capitated entity, not computed in aggregate and reducing all capitation payments. Option under 42 CFR 435.725(f) - The State can use a projection of expenses for a prospective period not to exceed 6 months to calculate client participation. This option requires the State to reconcile estimates with incurred expenses. Even with this option, the State must reduce the capitation rate to exclude expenses that are of the recipient's liability. This procedure ensures that the federal government does not pay more that its share of costs.			
AA.3.13	42 CFR 438.6(c)(3)(ii)	Claims Completion Factor Derivation (Mandatory) – When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use DOS data which is recent, "completion factors" must be used, which increase the reported totals to an estimate of their ultimate value after all claims have been reported. Such factors are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. • Claims completion factors are derived reflecting nuances in rate categories. Possible distortions in the factor are discussed with the State. Claims payment lag factors can be determined by rate cell or service category, the State should explain how they created the lag factors and what the lag factors are. • A claims completion factor table is created showing what adjustments are needed by category of service or eligibility category. This adjustment will	Contract or Ratesetting Documentation		

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		vary widely across states based on several factors: the number of months used for claim runout, the types of services paid on a FFS basis, the staffing level for claims processing, etc. A State with a high percentage of FFS claims filed electronically should have a very low claims completion factor. A State with a low percentage of FFS claims filed electronically may have a higher percentage claims completion factor depending upon how recent the base year data is. Time frames for FFS claims submission may affect the claims completion factor. Anomalies in claims payment patterns should be discussed between the State and the Actuary. *Note: for example, the Actuary understands how adjustment claims are handled in the MMIS system.* • Base period data is adjusted by the claims completion factors.			
AA.3.14	42 CFR 438.6(c)(3)(ii) and (iv) 42 CFR 447.60 42 CFR 438.6(c)(5)(v) 1923(i) 42 CFR 433 Sub D, 42 CFR 447.20, SMM 2089.7 FR 6/14/02 p41000	Other adjustments - Any adjustments made to the base period data based on historical data and future predictability should be explained. These adjustments may be additions or subtractions to the rates. Any adjustments (e.g., hospital price increases in excess of historic Medicaid fee schedules, etc) should be documented. • Payments and recoupments outside of the MMIS system for which the capitated entity will be responsible should be taken into account. • Certified Match (Mandatory, if applicable) - If a State places a service for which a public provider "certifies" the State share of the match, the State should make an adjustment to the rates to include the total costs of the service rather than just the federal share. • Pharmacy Rebates – States are no longer required to reduce the component of the capitation rate for prescription drugs by the amount of the drug rebates received by the State through its FFS system. If the State includes pharmacy in its capitated contract, the State **may** adjust the claims data for fee-for-service pharmacy rebates. However, the State is no longer obligated to adjust for the full FFS rebate amount. Instead, the state should set the pharmacy component of the capitation rate to reflect a rate that is actuarially sound. • Investment Income Factor - This factor adjusts capitation rates because FFS claims are paid after a service is provided while payments under managed care are made before the time of services. Since payments are made earlier, the equivalent amount of payment is slightly less, because the earlier payments would generate investment income between the date of receipts and the date of claim payment. A small reduction to the rate may be made. Factors to take into account include payment lags by type of provider; advances to providers; and the timing of payments to prepaid plans, relative to when services are	Contract or Ratesetting Documentation		

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		provided. • Managed Care Adjustment – This adjustment reflect care delivered in a managed care environment when FFS base data was used for utilization and cost assumptions. Under managed care there often are assumptions that primary care physician visits and the number of prescription drugs utilized will increase, but that these increased costs will be more than offset by reduced hospital inpatient, emergency room, and physician specialist costs. The managed care assumptions chosen should be reflective of an efficiently and effectively run entity. Periodic changes in the managed care assumptions may result from on-site operational reviews measuring the medical utilization and cost management effectiveness of the entity, or could derive from State and/or entity expectation of continuous improvement in the entity's medical utilization and cost management effectiveness. *Note: This adjustment may not be used in reverse to "back into" a fee-for-service equivalent rate based on encounter data. Capitated rates under 438.6(c) should be developed using an actuarially sound method appropriate to a risk contract for the Medicaid State Plan approved benefits.* • Financial Experience Adjustment – The actuary reviewed the entity's income statement, cash flow, and rate profit assumptions and adjusted the rates to reflect care delivered in an efficiently and effectively run capitated entity. This adjustment may be made in order to compensate for recent historical variation in actual to expected expenditures inherent in any ratesetting process. The adjustment may result in an upward or downward adjustment. *Note: for example, if recent historical ratesetting assumed a 90% medical claim cost loss ratio, and the actual audited or Department of Insurance submitted medical claim cost loss ratio for the same period was 88%, a 2% downward financial experience adjustment factor may be appropriate. Note: Prior to the RO approving this adjustment, the actuary must document that capitated rates are NOT be based upon cost and not compensating the entity for losses in prior contractual periods.* • PCCM case-management fee deduction - When States transition from a PCCM program to a capitated program and use the PCCM claims data to create capitated rates, any management fees paid to the PCCM must be deducted from the rates. • Other changes may be legislative, policy or programmatic changes or changes due to court-ordered settlements not anticipated or reflected in the base data.			

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		Note: CMS RO staff should use their knowledge of the State's data source and program to review these adjustments. All adjustments must be documented.			
Subsection AA.4 – Establish Rate Category Groupings					
AA.4.0	42 CFR 438.6(c)(3)(iii) FR 6/14/02 p41001	Establish Rate Category Groupings (All portions of subsection AA.4 are mandatory) -- The following rate category groupings listed in 4.1 to 4.5 were made to construct rates more predictable for future Medicaid populations' rate setting. The number of categories should relate to the contracting method. If diagnostic/health status risk adjustment is used, the RO will review under 5.2. *Note: The State must document that similar cost categories are grouped together to improve predictability. For example, rate cells may be combined if there is an insufficient number of enrollees in any one category to have statistical validity.* Rate cells need to be grouped together based upon predictability so entities do not have incentives to market and to enroll one group over another. Multiple rate cells should be used whenever the average costs of a group of beneficiaries greatly differ from another group and that cost can be easily identified. For example, if an older group of women with SSI in the southern portion of an entity service area have historically had higher costs in fee-for-service, the State should set higher rates for the entity to compensate them if any members match those demographic characteristics. *Note: Regarding the documentation to justify rate cell grouping, CMS wants the analyses performed by the State to document if average costs for individuals in different eligibility categories, ages, genders, and geographic locations vary. The State should submit this documentation each time it initially sets capitated rates or modifies rate cell structure. For example, if CMS finds that the average costs for individuals under age 13 versus over age 13 and the two different genders vary substantively, we would question statements where the State did not consider it significant enough to warrant multiple rates.*	Contract or Ratesetting Documentation		
AA.4.1	42 CFR 438.6(c)(3)(iii)(B)	Age - Age Categories are defined. If not, justification for the predictability of the methodology used is given. For example, newborns, children up to age 6, and women age 18-35 in childbearing years each have different costs. The State should justify having a single rate encompassing these three ages.	Contract or Ratesetting Documentation		
AA.4.2	42 CFR	Gender -Gender Categories are defined. If not, justification for the predictability	Contract or		

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	438.6(c)(3)(iii)(C)	of the methodology used is given. For example, women age 18-35 and men age 18-35 have different costs, but boys and girls under age 1 may not have different costs. The State should explain any combined gender rate cells.	Ratesetting Documentation		
AA.4.3	42 CFR 438.6(c)(3)(iii)(D)	Locality/Region - Locality/region Categories are defined. If not, justification for the predictability of the methodology used is given. For example, urban and rural areas should have separate rates.	Contract or Ratesetting Documentation		
AA.4.4	42 CFR 438.6(c)(3)(iii)(E)	Eligibility Categories - Eligibility Categories are defined. If not, justification for the predictability of the methodology used is given. For example, TANF populations have different costs than Aged and Disabled and Ward populations.	Contract or Ratesetting Documentation		
Subsection AA.5 – Data Smoothing					
AA.5.0	42 CFR 438.6(c)(3)(ii), (iii) and (iv) 42 CFR 438.6(c)(1)(ii)	Data Smoothing (All portions of subsection AA.5 are mandatory) - The State has examined the data for any distortions and adjusted in a cost-neutral manner for distortions and special populations. Distortions are primarily the result of small populations, special needs individuals, access problems in certain areas of the State, or extremely high-cost catastrophic claims. Costs in rate cells are adjusted through a cost-neutral process to reduce distortions across cells to compensate for distortions in costs, utilization, or the number of eligibles. This process adjusts rates toward the statewide average rate. The State must supply an explanation of the smoothing adjustment, an understanding of what was being accomplished by the adjustment, and demonstrate that, in total, the aggregate dollars accounted for among all the geographic areas after smoothing is basically the same as before the smoothing. The State has taken into account individuals with special health care needs and catastrophic claims. These populations should only be included if they are an eligible, covered population under the contract. Claim costs and utilization for high cost individuals (e. g., special needs children) in the managed care program are included in the rates.	Contract or Ratesetting Documentation		
AA.5.1	42 CFR 438.6(c)(3)(iv) FR 6/14/02 p41001	Special Populations and Assessment of the Data for Distortions – Because the rates are based on actual utilization in a population, the State must assess the degree to which a small number of catastrophic claims might be distorting the per capita costs. Other payment mechanisms and utilization and cost assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk-sharing, or other appropriate cost-neutral methods may be necessary.	Contract or Ratesetting Documentation		

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		If no distortions or outliers are detected by the actuary, a rate setting method that uses utilization and cost data for populations that include individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims will meet requirements for special populations without additional adjustments, since the higher costs would be reflected in the enrollees' utilization. States must document their examination of the data for outliers and smooth appropriately. The fact that the costs of these individuals are included in the aggregate data used for setting rates will not account for the costs to be incurred by a contractor that, due to adverse selection or other reasons, enrolls a disproportionately high number of these persons. CMS requires some mechanism to address this issue. Most entity contracts currently use either stop-loss, risk corridors, reinsurance, health status-based risk adjusters, or some combination of these cost-neutral approaches. *Note: The RO should verify that this assessment occurred and that distortions found were addressed in 5.2.*			
AA.5.2	42 CFR 438.6(c)(1)(iii) 42 CFR 438.6(c)(3)(ii) and (iv) SMM 2089.6 FR 6/14/02 p41001 & 41002	Cost-neutral data smoothing adjustment -- If the State determines that a small number of catastrophic claims are distorting the per capita costs then at least one of the following cost-neutral data smoothing techniques **must** be made. Cost neutral means that the mechanism used to smooth data, share risk, or adjust for risk will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments. Actuarially sound risk sharing methodologies will be cost neutral in that they will not merely add additional payments to the contractors' rates, but will have a negative impact on other rates, through offsets or reductions in capitation rates, so that there is no net aggregate assumed impact across all payments. A risk corridor model where the State and contractor share equal percentages of profits and losses beyond a threshold amount would be cost neutral. The mechanism should be cost neutral in the aggregate. How that is determined, however, will differ based on the type of mechanism that is used. A stop-loss mechanism will require an offset to capitation rates under the contract, based on the amount and type of the stop-loss. Health status-based risk adjustment may require an adjustment to the capitation rate for all individuals categorized through	Contract or Ratesetting Documentation		

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		the risk adjustment system, but the aggregate program impact will still be neutral. CMS will recognize that any of these mechanisms may result in actual payments that are not cost neutral, in that there could be changes in the case mix or relative health status of the enrolled population. As long as the risk sharing or risk adjustment system is designed to be cost neutral, it would meet this requirement regardless of unforeseen outcomes such as these resulting in higher actual payments. The RO should verify that the data smoothing was cost-neutral. ___ Provision of stop loss, reinsurance, or risk-sharing (See 8.0) ___ Catastrophic Claims Adjustment – The State must identify that there are outlier cases and explain how the costs associated with those outlier cases were separated from the rate cells and then redistributed across capitation payment cells in a cost-neutral, yet predictive manner. ___ Small population or small rate cell adjustment – The State has used one of three methods: 1) The actuary has collapsed rate cells together because they are so small, 2) the actuary has calculated a statewide per member per month for each individual cell and multiplied regional cost factors to that statewide PMPM in a cost-neutral manner, or 3) the actuary bases rates on multiple years data for the affected population weighted so that the total costs do not exceed 100% of costs (e.g., 3 years data with most recent year's data weighted at 50%, 2nd most recent year's data weighted at 30% and least recent year weighted at 20%). ___ Mathematical smoothing – The actuary develops a mathematical formula looking at claims over a historical period (e.g., 3 to 5 years) that identifies outlier cost averages and corrects for skewed distributions in claims history. The smoothing should account for cost averages that are higher and lower than normal in order to maintain cost-neutrality. ___ Risk-adjustment based upon enrollees' health status or diagnosis. The State has chosen to employ statistical methodologies to calculate diagnosis-based risk adjusters using accepted diagnosis groupers. The State explains the risk assessment methodology chosen, documents how payments will be adjusted to reflect the expected costs of the disabled population, and demonstrates how the particular methodology used is cost-neutral. The State has outlined periodic monitoring and/or rebasing to ensure that the overall payment rates do not artificially increase, due to providers finding more creative ways to			

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		classify individuals with more severe diagnoses (also called upcoding or diagnosis creep). Risk-adjustment must be cost-neutral. Voluntary programs using risk-adjustment should document acuity changes due to biased selection on AA.1.3. *Note: for example, risk-adjustment cannot add costs to the managed care program. Risk adjustment can only distribute costs differently amongst contracting entities.* ***Note: The RO should apply the forthcoming attachment to this appendix in the review of risk-adjustment techniques.*** ___ Maternity Kick-Payment (Per delivery rate) – Non-delivery related claims were separated from delivery related claims. The non-delivery related claims were sorted into categories of service and used to base the managed care capitation payments. Delivery-related costs were removed from the total final paid claims calculations. The State developed a tabulation of per-delivery costs only. The State reviewed the data for accuracy and variance. The State develops a single, average, per-delivery maternity rate across all cohorts and across all regions unless variance warrants region-specific per-delivery maternity rates. Some states also have birth kick payments to cover costs for a newborn's birth (Per newborn rate). ___ Applying other cost-neutral actuarial techniques to reduce variability of rates and improve average predictability. If the State chooses to use a method other than the catastrophic claims adjustment or a small population or small rate cell adjustment, the State explains the methodology. The actuary assisted with the development of the methodology, the approach is reasonable, the methodology was discussed with the State, and an explanation and documentation is provided to CMS.			
Subsection 6.0 – Calculation of Capitation Rates					
AA.6.0	42 CFR 438.6(c)(2)(i) and (ii) SMM 2089.1	<u>Calculation of Capitation Rates (Mandatory)</u> - Capitation rates to provide State Plan approved services cannot exceed 100% of the amount calculated using an actuarially sound method. (See 1.1 and 1.2 for acceptable calculation techniques) The contract must specify the payment rates and the actuarial basis of the methodology used to compute those rates. *Note: If the State Plan or waiver requires that the State consider post-eligibility treatment of income for institutionalized beneficiaries, the actual rate paid to the capitated entity would be the rate for the member minus any patient liability for that specific enrolled member. The State should calculate the client participation*	Contract		

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		amount specifically for each member using the FFS methodology.			
Subsection 7.0 – Projection of expenditures					
AA.7.0	42 CFR 438.6(c)(4)(iii)	Projection of expenditures (Mandatory) -The State must provide a projection of total expenditures under its previous year's contract (or under its FFS program if it did not have a contract in the previous year) compared to those projected under the proposed contract. *Note: The State should hold enrollment constant (i.e., use either projected or past enrollment – but not both) showing the aggregate cost at the old rates versus the new rates. Entity expenditures include State Plan service capitated costs, 1915(b)(3) and 1115(a) service payments, risk-sharing outlays and incentives. Each should be distinguished.*	Contract or Ratesetting Documentation		
Subsection 8.0 – Stop Loss, Reinsurance, or Risk-sharing arrangements					
AA.8.0	42 CFR 438.6(c)(4)(iv) 42 CFR 438.6(c)(5)(i) 42 CFR 438.6(c)(2)(ii) FR 6/14/02 p41004	Stop Loss, Reinsurance, or Risk-sharing arrangements (8.0 is mandatory if the State chooses to offer one of these options) *(State Optional Policy)* – The State must submit an explanation of state's reinsurance, stop loss, or other risk-sharing methodologies. These methodologies must be computed on an actuarially sound basis. *Note: If the State utilizes any of the three risk-sharing arrangements, please mark the applicable method in 8.1, 8.2, or 8.3. For most contracts, the three options are mutually exclusive and a State will use only one technique per contract. If a State or contract uses a combination of methodologies in a single contract, the State must document that the stop loss and risk-sharing do not cover the same services simultaneously. Plans are welcome to purchase reinsurance in addition to State-provided stop loss or risk-sharing, but CMS will not reimburse for any duplicative cost from such additional coverage.* The contract must specify any risk-sharing mechanisms, and the actuarial basis for computation of those mechanisms. *Note: In order for the mechanism to be approved in the contract, the State or its actuary will need to provide enough information for the reviewer to understand both the operation and the financing of the risk sharing mechanism.* Capitation rates are based upon the probability of a population costing a certain rate. Even if the entity's premium rates are sufficient to cover the probable average costs for the population to be served, the entity is always at risk for the improbable – two neonatal intensive care patients and one trauma victim in its	Contract		

Item #	Legal Cite	Subject	Where Located	Met or NA	Comments
		first 100 members, or an extraordinarily high rate of deliveries. A new entity, with a small enrollment to spread the risk across, could be destroyed by one or two adverse occurrences if it were obliged to accept the full liability. FFP is not available to fund stop loss and risk-sharing arrangements on the provision of non-State Plan services.			
AA.8.1	42 CFR 438.6(c)(4)(iv) 42 CFR 438.6(c)(5)(i)	Commercial Reinsurance – The State requires entities to purchase commercial reinsurance. The State should demonstrate that the contractor has ensured that the coverage is adequate for the size and age of the entity.	Contract		
AA.8.2	42 CFR 438.6(c)(4)(iv) 42 CFR 438.6(c)(5)(i) SMM 2089.6	Simple stop loss program -- The State will provide stop-loss protection by writing into the contract limits on the entity's liability for costs incurred by an individual enrollee over the course of a year (either total costs or for a specific service such as inpatient care). Costs beyond the limits are either entirely or partially assumed by the State. The entity's capitation rates are reduced to reflect the fact that the State is assuming a portion of the risk for enrollees. ■ The State has documented the creation of a claims frequency distribution (claims tail lag triangle). - The State creates a frequency distribution of claims for the individuals who exceeded the stop-loss limit (or counts the number and costs of the individuals above the limit). Using the frequency distribution, the State calculates the percent of the population whose costs are above the desired stop-loss limit and calculates the PMPM rate withhold that it would cost the State to assume the risk for those individuals. ■ The State has included in its documentation to CMS the expected cost to the State of assuming the risk for the high cost individuals at the chosen stop-loss limit (also called stop-loss attachment point). ■ An explanation of the State's stop loss program includes the amount/percent of risk for which the State versus entity will be liable. ■ The State has explained liability for payment. In some contracts, the entity is liable up to a specified limit and partially liable for costs between that limit and some higher number. The State is wholly liable for charges above the higher limit. If there is shared risk rather than either the State or the entity entirely assuming the risk at a certain point, the entity and State determine whether the services will be reimbursed at Medicaid rates, at the entities'	Contract		

Item #	Legal Cite	Subject	Where Located	Met or NA	Comments
		rates, or on some other basis. The State must specify which provider rates will be used to establish the total costs incurred so that the entity clearly knows whether the reinsurance will pay (i.e., the attachment point is reached). ■ The State has deducted a withhold equal to the actuarially expected cost to the State of assuming the risk for high cost individuals. The State pays out money based on actual claims that exceed the stop loss limit (i.e., above the attachment point). ■ The State has documented whether premiums will be developed by rate cell or on a more aggregated basis.			
AA.8.3	42 CFR 438.6(c)(4)(iv) 42 CFR 438.6(c)(5)(i) and (ii) 42 CFR 438.6(c)(1)(v)	Risk corridor program – Risk corridor means a risk sharing mechanism in which States and entities share in both profits and losses under the contract, outside of a predetermined threshold amount, so that after an initial corridor in which the entity is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses, and receives a portion of any additional profits. If risk corridor arrangements result in payments that exceed the approved capitation rates, these excess payments will not be considered actuarially sound to the extent that they result in total payments that exceed the amount Medicaid would have paid, on a fee-for-service basis, for the State plan services actually furnished to enrolled individuals, plus an amount for entity administrative costs directly related to the provision of these services. The State agrees to share in both the aggregate profits and losses of an entity and protect the entity from aggregate medical costs in excess of some predetermined amount. To the extent that FFP is involved, CMS will also share in the profits and losses of the entity. In this instance, the State and CMS must first agree upon the benchmark point up to which federal match will be provided. Federal matching is available up to the cost of providing the same services under a non-risk contract (i.e., the services reimbursed on a Medicaid fee-for-service basis plus an amount for entity administrative costs related to the provision of those services). See 447.362. States typically require entities to adopt the Medicare cost-based entity principles for the purposes of calculating administrative costs under this model.	Contract		

Item #	Legal Cite	Subject	Where Located	Met or NA	Comments
		Note: For this example, let's say the payment is $100 and there are 10 members expected to enroll. The total capitated payment CMS will match is $1,000. - *The State and the entity must then agree on the amount of risk to be shared between them (e.g., 5% or the risk corridor is between $950 and $1,050).* - *The entity must calculate its overall costs at the end of the year and submit them to the State.* - *Scenario 1, the entity costs are $950: In this example, the entity's profits are within the risk corridor of $950 to $1,050, so the entity keeps the entire amount of capitated payments and no adjustment is made.* - *Scenario 2, the entity costs are $1,050: In this example, the entity's loss is within the risk corridor, so the entity keeps the entire amount of the capitated payment and no adjustment is made.* - *Scenario 3, the entity costs are $850: In this example, the entity profit is outside of the risk corridor, so the entity must pay the State the amount of the excess profit or $100.* - *Scenario 4, the entity costs are $1,150: In this example, the entity loss is outside of the risk corridor, so the State must pay the entity the amount of the excess loss or $100.* *Please note: FFP is not available for amounts in this contract over the fee-for-service cost of providing these services. In order to compute the fee-for-service cost of providing services, the State must "price" the capitated entity's encounter data through the State's fee-for-service MMIS system. Amounts exceeding the cost of providing these services through a non-risk contract are not considered actuarially sound. The State must "price" the encounter data for entities with open ended risk-corridors (meaning there is no limit to the State's liability) when the entity exceeds the aggregate of actuarially sound rates x member months by more than 25%. In practice the RO may require the "pricing" of encounter data whenever evidence suggests that the non-risk threshold has been exceeded. Similarly, the State can require documentation if evidence suggests that the entity should be profit sharing below the threshold. In this example, if the fee-for-service and entity administrative cost of providing these services were $1,100, then FFP would only be available up to $1,100. See 42 CFR 447.362 or Step AA.1.8 of this checklist.*			
Subsection AA.9.0 – Incentive Arrangements					

Item #	Legal Cite	Subject	Where Located	Met or NA	Comments
AA.9.0	42 CFR 438.6(c)(4)(iv) 42 CFR 438.6(c)(5)(iii) and (iv) SMM 2089.3 42 CFR 438.6(c)(2)(i) 42 CFR 438.6(c)(1)(iv) 42 CFR 438.6(c)(4)(ii)	<u>Incentive Arrangements (9.0 is mandatory if the State chooses to implement an incentive)</u> *(State Optional Policy)* – Incentive arrangement means any payment mechanism under which an entity may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract. The State must include an explanation of the State's incentive program. In general, the capitated rates were developed based upon the provision of Medicaid State Plan approved services. Payments in contracts with incentives may not exceed 105% of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement. • Any additional incentives must be actuarially sound and based upon the provision of Medicaid State Plan approved services to Medicaid eligible beneficiaries (note: 1915(b)(3) and 1115(a)(2) services and the provision of all other non-State plan services require specific statutory authority and approval from CMS. Neither type of services may be included in capitated incentives under the regulation. Payments for 1915(b)(3) and 1115(a) payments should be calculated separately. See also AA.2.3). • The incentive must be conditioned upon a specified activity to occur or a target to be met. The incentives must be affected by the entity's actual performance or non-performance of the contract and must vary based upon the cost of providing Medicaid services to Medicaid enrollees. No federal match is available for incentive payments or bonuses for agreeing to enter into risk contracts that meet the following criteria regardless of the waiver or State plan authority: ♦ A reward for signing a valid and binding contract and not affected by the entity's actual performance or non-performance or any aspect of the contract itself (i.e., the incentives are not actuarially sound). ♦ The amount of the payment does not vary based upon the cost of providing services in the area served by the entity. ♦ The payment is made to any entity that signs or renews a risk contract with the State as an incentive to do so. • Total payments to contractors cannot include payments for non-State Plan approved services. • Incentives cannot be renewed automatically and must be for a fixed time period. • The incentive cannot be conditioned upon intergovernmental transfer agreements.	Contract		

Item #	Legal Cite	Subject	Where Located	Met or NA	Comments
		• Incentives must be available to both public and private contractors. *Note: The limitation in 9.0 calculation of capitation rates is affected by this requirement if the State provides for incentives for meeting a particular performance goal. For example, the capitation rates are developed assuming a set target rate. The capitation rate actually paid to a health plan is based on actual performance. If the target is exceeded, the capitation rate is increased to reflect the actual services provided. In the case of the later, the actual capitation paid may exceed the capitation rate calculated based on the original target only up to the 105% limitation on federal match.* *Note: Reinsurance collections from reinsurance purchased from a private vendor (See 8.1) and State provided stoploss (8.2) are actuarially calculated to be cost-neutral and should not considered to be "incentives" or included in these payments.*			
Subsection 10.0 – Rate Update					
AA.10.0	42 CFR 438.6(c)(4)(i) and (ii) 42 CFR 438.6(c)(2)(i) and (ii) 42 CFR 438.6(c)(1)(i)(A) and (C) 42 CFR 438.6(2)(ii) 42 CFR 438.6(c)(3) SMM 2089.5	<u>Rate Updates (10.0 and 10.1 is mandatory for any rate update. Use 10.2-10.4 only to the extent there have been changes in these items)</u> - This section is for use when a State does not rebase the rates in a contract extension on a new actuarial technique or different utilization data base than the one that was used previously. States should rebase the rates every 3 years. *Note:In absence of supporting documentation showing validation of predictableness and a plan to update data, ROs should not approve rates that have not been rebased at least every 5 years. At the date of rebasing, the oldest data that may be used can be no older than five years; however, after rebasing, up to two additional years of rates may be calculated by rolling forward these rates, without rebasing. This practice would result in the base data being seven years old at the end of its useful life.* Simple trend and adjustment updates (using criteria 10.1 to 10.4) may be performed annually otherwise. All capitation rates paid under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound. *Note: rebase means the update/creation of new rates with new base year data that the actuary has analyzed. If a state is updating rates, the State is taking the base year data used previously and applying trend rates without creating a base year of more recent or different data.*	Contract		

Item #	Legal Cite	Subject	Where Located	Met or NA	Comments
		The contract must specify the payment rates and any risk-sharing mechanisms, and the actuarial basis for computation of those rates and mechanisms. Were the rates in the original contract period set in an actuarially acceptable manner in which CMS approved the methodology using a checklist similar to this for Steps AA.1 to AA.9? Rates approved prior to the release of 42 CFR 438.6 must comply with the regulation by the period specified in the FR. CMS allows rate changes (regardless of whether they are reductions or augmentations) and provides FFP in such changes as long as the changes are implemented through either a formal contract amendment or a multi-period contract and continue to meet all applicable statute provisions and regulations. If rate changes are implemented through a contract amendment, the amendment must receive prior approval by the RO before FFP in any higher payment amounts may be awarded. If the rate change is an anticipated development in a multi-year process, it must also be reviewed by the RO, consistent with guidelines for multi-year contracts.			
AA.10.1	42 CFR 438.6(c)(4)(iii)	Projection of expenditures -The State must provide a projection of expenditures under its previous year's contract (or under its FFS program if it did not have a contract in the previous year) compared to those projected under the proposed contract. *Note: The State should hold enrollment constant (i.e., use either projected or past enrollment – but not both) showing the aggregate cost at the old rates versus the new rates.*	Contract or Ratesetting Documentation		
AA.10.2	42 CFR 438.6(c)((4)(ii)(A)	Program Differences –New benefits under the State's FFS program that have been incorporated into the State Plan should be added through this adjustment when rates are updated. The value of these programmatic service changes should be documented. Services provided by the managed care plan that exceed the services covered in the Medicaid fee-for-service program (i.e., the Medicaid State Plan) may not be used to set capitated Medicaid managed care rates. Were program changes since the rates were originally set appropriately accounted for? Differences in the service package for the last rate period and the new Medicaid managed care covered service package are adjusted in the rates. Documentation of assumptions and estimates is required if this adjustment is made.	Contract or Ratesetting Documentation		

Item #	Legal Cite	Subject	Where Located	Met or NA	Comments
		Note: If other programmatic changes in the managed care program (or FFS program that affected the managed care program) were made after the last set of rates were set , the State may adjust for those changes if: • *The adjustment is made only once (e.g., if the State projected the effect of a change in the last rate setting, then they must back out that projection before applying an adjustment for the actual policy effect)* • *Documentation fitting the requirements in step AA.3.0 – AA.3.14 is submitted to the RO for new adjustments. For example: Utilization Adjustment – Utilization adjustments reflect the change in the frequency of medical procedures over time. As part of a rate update, utilization trend would be estimated from the current contract period to the new contract period. See step AA.3.11.*			
AA.10.3	42 CFR 438.6(c)(3)(ii) FR 6/14/02 p41000	<u>Cost trending (Inflation)</u> – Medical inflation factors are based on historical medical State-specific costs or a national/regional medical market basket applicable to the state and population. Justification for the predictability of the inflation rates is given regardless of the source. Differentiation of trend rates is documented (i.e., differences in the trend by service categories, eligibility category, etc). All trend factors and assumptions are explained and documented. *See Step AA.3.10.* *Note: this also includes price increases not accounted for in inflation such as price increases in Medicaid fee-for-service or managed care program made after the claims data tape was cut. This adjustment is made if price increases are legislated by the Legislature. The RO must ensure that the State "inflates" the rate only once and does not double count inflation and legislative price increases (i.e., review original rates and all subsequent increases to ensure that rates reflect only one "increase" per year). The State must document that program price increases since the rates were originally set are appropriately made.*	Contract or Ratesetting Documentation		
AA.10.4	42 CFR 438.6(c)(4)(iv)	<u>Risk-sharing or Incentives -</u> An explanation pertinent to the current contract year of any incentive arrangements, or stop-loss, reinsurance, or any other risk-sharing methodologies under the contract is provided. See Step AA.8 and AA.9 above for the policies and documentation necessary.	Contract or Ratesetting Documentation		

MEDICARE/MEDICAID
DUAL ELIGIBLE CATEGORIES
(EACH MEDICAID CATEGORY IS ENTITLED TO MEDICARE)

Eligibility Category	Medicaid Benefits	Cost Limit to Medicaid (if any)	Provider	Medicaid Liability for Services
QMB only	Medicare premiums, deductibles, and coinsurance (crossover) No Medicaid services	Full Medicare	Medicare	QMB rates for Medicare deductibles and coinsurance Includes any M+C premiums if the State has chosen to cover in the State Plan on page 29.
QMB PLUS (QMB + Medicaid)	Medicare premiums, deductibles, and coinsurance (crossover) Medicaid services	Full Medicare + Medicaid	Medicare Medicaid	QMB rates for Medicare deductibles and coinsurance Medicaid rates for Medicaid only services Includes any M+C premiums if the State has chosen to cover in the State Plan on page 29.
MEDICAID (Non QMB and Non SLMB)	Medicare Part B premiums (optional for medically needy) Medicaid services	$58.70 + Medicaid	Medicare Medicaid	No liability for Medicare deductibles and coinsurance Difference between Medicare payment and Medicaid rates for Medicaid services
SLMB only	Medicare Part B premiums No Medicaid services	$58.70	Medicare	No liability for Medicare deductibles and coinsurance
SLMB PLUS (SLMB + Medicaid)	Medicare Part B premiums Medicaid services	$58.70 + Medicaid	Medicare Medicaid	No liability for Medicare deductibles and coinsurance Difference between Medicare payment and Medicaid rates for Medicaid services
QDWI (Not otherwise eligible for Medicaid)	Medicare Part A premiums	$316 http://www.medicare.gov/Basics/Amounts2002.asp	Medicare	No liability for Medicare deductibles and coinsurance
QI (Not otherwise eligible for Medicaid)	All or part of Medicare Part B premiums	Q1 – $ 58.70 ~~Q2 - $3.91 in 2002~~	Medicare	No liability for Medicare deductibles and coinsurance Effective January 1, 2003, the QI-2 benefit is no longer authorized and states should provide notice to the QI-2 beneficiaries of the termination action to be taken, consistent with the rules on advance notice at 42 CFR 431.211. You are currently required to pay $3.91 per month toward the Medicare Part B premiums for QI-2s through

				December 31, 2002.

Current Rate Requirements

Capitation payment means a payment the State agency makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services under the State plan. The State agency makes the payment regardless of whether the particular recipient receives services during the period covered by the payment. 42 CFR 438.2

Non-risk contract means a contract under which the contractor-- (1)Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in §447.362 of this chapter; and (2)May be reimbursed by the State at the end of the contract period on the basis of the incurred costs, subject to the specified limits. 42 CFR 438.2

Risk contract means a contract under which the contractor--
- Assumes risk for the cost of the services covered under the contract and
- Incurs loss if the cost of furnishing the services exceeds the payments under the contract. 42 CFR 438.2

Actuarially sound capitation rates means capitation rates that—
- have been developed in accordance with generally accepted actuarial principles and practices;
- are appropriate for the populations to be covered and the services to be furnished under the contract; and
- have been certified, as meeting the requirements of the regulation, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

Adjustments to smooth data means adjustments made, by cost-neutral methods, across rate cells, to compensate for distortions in costs, utilization, or the number of eligibles.

Cost neutral means that the mechanism used to smooth data, share risk, or adjust for risk will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments.

Incentive arrangement means any payment mechanism under which a contractor may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract.

Risk corridor means a risk sharing mechanism in which States and contractors share in both profits and losses under the contract outside of predetermined threshold amount, so that after an initial corridor in which the contractor is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses, and receives a portion of any additional profits.

Basic requirements.
All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound. The contract must specify the payment

rates and any risk-sharing mechanisms, and the actuarial basis for computation of those rates and mechanisms.

Requirements for actuarially sound rates. In setting actuarially sound capitation rates, the State must apply the following elements, or explain why they are not applicable:

- Base utilization and cost data that are derived from the Medicaid population, or if not, are adjusted to make them comparable to the Medicaid population.
- Adjustments made to smooth data and adjustments to account for factors such as medical trend inflation, incomplete data, MCO, PIHP, or PAHP administration (subject to the limits in paragraph (c)(4)(ii) of this section), and utilization;
- Rate cells specific to the enrolled population, by--
  - (A) Eligibility category;
  - (B) Age;
  - (C) Gender; and
  - (D) Locality/region; or
  - (E) Risk adjustments based on diagnosis or health status (if used).
- Other payment mechanisms and utilization and cost assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk sharing, or other appropriate cost-neutral methods.

Documentation. The State must provide the following documentation:

- The actuarial certification of the capitation rates.
- An assurance (in accordance with paragraph (c)(3) of this section) that all payment rates are—
  - (A) Based only upon services covered under the State plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration).
  - (B) Provided under the contract to Medicaid-eligible individuals.
- The State's projection of expenditures under its previous year's contract (or under its FFS program if it did not have a contract in the previous year) compared to those projected under the proposed contract.
- An explanation of any incentive arrangements, or stop-loss, reinsurance, or any other risk-sharing methodologies under the contract.

Special contract provisions.

- Contract provisions for reinsurance, stop-loss limits or other risk-sharing methodologies must be computed on an actuarially sound basis.
- If risk corridor arrangements result in payments that exceed the approved capitation rates, these excess payments will not be considered actuarially sound to the extent that they result in total payments that exceed the amount Medicaid would have paid, on a fee-for-service basis, for the State plan services actually furnished to enrolled individuals, plus an amount for MCO, PIHP, or PAHP administrative costs directly related to the provision of these services.
- Contracts with incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such total payments will not be considered to be actuarially sound.
- For all incentive arrangements, the contract must provide that the arrangement is--

(A) For a fixed period of time;
(B) Not to be renewed automatically;
(C) Made available to both public and private contractors;
(D) Not conditioned on intergovernmental transfer agreements; and
(E) Necessary for the specified activities and targets.

If a State makes payments to providers for graduate medical education (GME) costs under an approved State plan, the State must adjust the actuarially sound capitation rates to account for the GME payments to be made on behalf of enrollees covered under the contract, not to exceed the aggregate amount that would have been paid under the approved State plan for FFS. States must first establish actuarially sound capitation rates prior to making adjustments for GME.

438.6(e)
Services that may be covered. An MCO, PIHP, or PAHP contract may cover, for enrollees, services that are in addition to those covered under the State plan, although the cost of these services cannot be included when determining the payment rates under §438.6(c).

42 CFR 438.60
Limit on payment to other providers. The State agency must ensure that no payment is made to a provider other than the MCO, PIHP, or PAHP for services available under the contract between the State and the MCO, PIHP, or PAHP, except when these payments are provided for in title XIX of the Act, in 42 CFR, or when the State agency has adjusted the capitation rates paid under the contract, in accordance with §438.6(c)(5)(v), to make payments for graduate medical education.

42 CFR 447.15, 42 CFR 438.2, 42 CFR 438.812(a)
Risk contracts – the entity assumes risk for the cost of services covered under the contract and incurs loss if the cost of furnishing the services exceed the payments under the contract. The entity must accept as payment in full, the amount paid by the State plus any cost sharing from the members. Payments for carrying out contract provisions are medical assistance costs.

42 CFR 447.15, 42 CFR 438.2, 42 CFR 438.812(b), 42 CFR 447.362
Non-risk contracts – the entity is not at financial risk for changes in utilization or for costs incurred that do not exceed the UPL in 447.362. The entity may be reimbursed at the end of the contract period on the basis of incurred costs. The entity must accept as payment in full, the amount paid by the State plus any cost sharing from the members. The amount for administration is reimbursed at the administrative match rate. The amount for reimbursing for services (not administrative-related) is a medical assistance cost.

1923(i)
DSH Payments *[contracts signed after 7/1/97]* – DSH payments may not be in capitation payments; must be paid by State to DSH facility.

42 CFR 433 Sub D, 42 CFR 447.20, SMM 2089.7
TPL and Rate – contract must specify any activities the entity must perform related to third party liability. The ratesetting documentation must address third party liability payments and whether the State or the entity will retain TPL collections.

42 CFR 447.60
Contracts with entities must provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the requirements set forth in 447.50 and 447.53 through 447.58 for cost sharing charges imposed by the State agency.

42 CFR 447.58 and SMM 2089.8
Copayments, Coinsurance and Deductibles - If the agency contracts with a pre-paid capitation organization that does not impose the agency's deductibles, coinsurance, co-payments or similar charges on its recipient members, the State must calculate its payments to the organization as if those cost sharing charges were collected.

42 CFR 447.53(e) No provider may deny services, to an individual who is eligible for the services, on account of the individual's inability to pay the cost sharing.

447.362 Non-risk contract limit.
Non-risk contract limit – Under a non-risk contract, Medicaid payments to the contractor may not exceed:

- What Medicaid would have paid, on a fee-for-service basis, for the services actually furnished to recipients plus
- The net savings of administrative costs the Medicaid agency achieves by contracting with the plan instead of purchasing the services on a fee-for-service basis.

42 CFR 447.15 SMM 2089.4, Hospital and NF Payment Rates – States have the option of requiring hospitals and NFs to accept the FFS payment rate as payment in full from a risk based Medicaid contracting MCO. The State may guarantee the FFS hospital or NF rate to the MCO if the provider participates in Medicaid. If the State chooses to exercise this option, the State may wish to specify this as a requisite for the institutional provider to become a participating provider. Some states presently apply this policy. The State must determine whether it requires legislation in order to accomplish this.

Appendix 3
Glossary of Terms

As used in this document, unless otherwise provided or the context otherwise requires, the following definitions of terms will govern the construction of this document.

ACCURACY: The quality or state of being exact or precise: free from making mistakes or errors.

ADDENDUM: An addition or change made to the RFP before the contract is signed into effect. The contract will include addenda added to the RFP.

ADMINISTRATIVE BULLETIN: Bulletins released to all potential Proposers who have submitted Letters of Interest or entities who have requested to be placed on the RFP permanent mailing list and may include addenda or additional information or data.

AFFILIATE: An organization or person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under control of the Contractor and that provides services to or receives services from the Contractor.

ATTACHMENTS: Exhibits and special or unique materials relating to the requirements attached to the contract and incorporated by reference.

ATTESTATION OF UNDERSTANDING/AGREEMENT: A Contractor's formal declaration of understanding of the terms requested and required by the RFP.

ATTORNEY GENERAL: The name commonly used to refer to any of the deputies on the staff of the Office of the Attorney General of the State of California.

BENEFICIARY: A person who is determined eligible for the Medi-Cal program.

BID: A potential Contractor's reply to solicitation for purchase of goods or services that represents what the Contractor would charge to provide those goods or services.

BIDDER: An individual, sole proprietorship, firm, partnership, corporation, or any other business venture that responds to a RFP by submitting a bid to the contracting agency. Synonymous with the term Proposer.

BILLABLE HOURS: The Contractor's billable hours are the lower of the actual hours incurred by the Contractor or the Contractor's estimated hours located in the most recent approved project plan. See Exhibit A for additional information on the project plans.

BILLABLE RATE(S): The completed Cost Proposal Form will identify the Proposer's billable rates for the each position identified on the form. The billable rates are to include all estimated costs to perform the services for the entire term, including applicable annual rate adjustments attributable to merit increases, profit margins, and inflation or cost of living adjustments. Any applicable personnel not specifically indicated on the Cost Proposal Form (i.e., management, clerical, support staff) should be factored into the indicated positions' billable rates.

CAPITATION PAYMENT: A payment DHS makes on a monthly basis to a contractor on behalf of each recipient enrolled under a managed care contract for the provision of medical services under the State plan based on a contracted per member per month capitation rate. DHS makes

the payment regardless of whether the particular recipient receives services during the period covered by the payment (42 CFR 438.2).

CARRIER: Any insurer, including any private company, corporation, mutual association, trust fund, reciprocal or inter-insurance exchange authorized under the laws of California to insure persons against liability or injuries caused by another.

CENTERS FOR MEDI-CARE AND MEDICAID SERVICES (CMS): The section within the federal Department of Health and Human Services, which manages the federal Medicaid Program.

CONTRACT: A legally binding agreement between the State and another entity, public or private, for the provision of goods or services.

CONTRACT EFFECTIVE DATE: The date upon which the terms of the contract go into effect. Date is specified in the contract on the standard contract form.

CONTRACT NUMBER: The seven-digit number assigned to the RFP and contract for tracking purposes. The contract number must be affixed to the proposal submission and accompany all communications with the State regarding the proposal or contract.

CONTRACT REQUIREMENT/DELIVERABLE: Any service, deliverable or other duty that the Contractor is required to provide or perform under the terms of the contract.

CONTRACT TERM: Used to identify the starting and ending date of the contract and/or the time allowed for the performance and completion of the contract.

CONTRACT OFFICER: Responsible party within the State who has authority to enter into a contract with the proposer and is responsible for managing the contract.

CONTRACTOR: The individual, company, public entity or organization that has been awarded a contract.

CONTRACTOR'S COST: The actual cost of expenses incurred by the Contractor to perform any task as part of this contract.

CONTRACTOR'S REPRESENTATIVE: The Contractor's official representative responsible for managing the Contractor's operation.

CORRECTIVE ACTION PLAN: Specific identifiable activities or plans of action necessary to correct deficiencies or problems identified by formal audits, formal reviews, or State monitoring activities.

COST PROPOSAL: A sealed, written and signed Cost Proposal form (Attachment 16), which includes the Proposer's billable rates for the identified positions. The cost proposal is offered in response to a formal or informal request for bid.

DATA: Facts, or a collection of facts, used to make a judgment.

DEPARTMENT: Refers to the State of California Department of Health Services.

DEPARTMENT OF HEALTH SERVICES (DHS): The single State agency responsible for administration of the Medi-Cal fee-for-service, Medi-Cal managed care, County Medical Services, California Children Services, and other related programs.

DIRECTOR: Refers to the Director of the Department of Health Services.

DISPUTE: A controversy arising under this contract between the State and the Contractor regarding the Contract Officer's determinations concerning the terms and conditions and contractual obligations embodied in this contract.

ESCROW BID DOCUMENTS: The Escrow Bid Documents shall include all labor costs, equipment costs, copies of quotations from subcontractors and suppliers, and memoranda, narratives, consultant's reports, add/deduct sheets, and all other information used by the bidder to arrive at the billable rates contained in the Cost Proposal.

The Escrow Bid Documents, of the proposer who is awarded the Contract, will be held in escrow for the duration of the contract. Escrow Bid Documents will be used to assist in the negotiation for the settlement of claims, in the resolution of disputes, and in Change Order/Contract Amendment pricing.

FEE-FOR-SERVICE (FFS): A method of charging based upon billing for a specific number of service units rendered to an eligible beneficiary. Fee-For-Service is the traditional method for reimbursement used by physicians. Payment almost always occurs retroactively (i.e., after the service has been rendered).

HEALTH CARE ACTUARY: This is a full professional level position. The individual must possess an associateship or fellowship in the Society of Actuaries or the Casualty Actuarial Society, and membership in the American Academy of Actuaries. Under direction of the Senior Health Care Actuary, the individual performs the actuarial work involved in the examination of health care related data, and provides valuations based on actuarial and statistical analysis; may act as a lead to non-actuarial personnel; and works under the direction of the Senior Health Care Actuary. The individual must have knowledge of managed care principles, and the different types of managed care models and their financial structures.

LETTER OF INTEREST: A letter sent to the State by a potential Proposer expressing interest in submitting a Technical Proposal and Cost Proposal. The letter identifies the prime Contractor, address, liaison person(s) and any other proposed Contractor/Subcontractor(s).

MANAGED CARE: A planned, comprehensive approach to the provision of health care that combines clinical services and administrative procedures within an integrated, coordinated system that is carefully constructed to provide timely access to primary health care and other necessary services in a cost-effective manner.

MANAGEMENT CONSULTANT: The individual must possess a working knowledge of the financial and operational aspects of health care industry including managed care and Medicaid. The individual will typically provide analyses and recommendations, provide oral and written narratives, and attend briefings and meetings with actuaries and supervisory staff.

MEDICAID (TITLE XIX): The program authorized by Title XIX of the Social Security Act to provide medical benefits for certain low-income persons.

MEDI-CAL PROGRAM: Medicaid Program administered by the State of California per Title XIX Federal Medical Assistance Program to provide Federal and State financial assistance for health and medical care of needy persons meeting program eligibility standards.

MEDI-CAL MANAGED CARE DIVISION (MMCD): The division within the Department of Health Services, Medical Care Services, which is responsible for implementing and monitoring the Medi-Cal Managed Care Program, and its related managed care health plans

MEDICARE (TITLE XVIII): The program authorized by Title XVIII of the Social Security Act of 1965 to provide payment for health services to the population aged 65 and over.

OFFICE OF MEDI-CAL PROCUREMENT (OMCP): The office responsible for all DHS Medi-Cal related procurements.

PROPOSAL: A potential Contractor's sealed written proposal of costs and approaches/ methods to be used in the performance of a particular service. Specifically, in this document, the Proposal is the two-part (Technical and Cost Proposal) written response to the RFP.

PROPOSER: An individual, sole proprietorship, firm, partnership, corporation, or any other business venture that responds to an RFP by submitting a bid to the contracting agency. Synonymous with the term Bidder.

PROPRIETARY: Ownership such as held under patent, trademark, or copyright. The term can include information (contract data) which is unique to a company and which, in the hands of a competitor, would be detrimental to the company.

PROVIDER: An individual, group, or institution licensed to provide medical care.

REQUEST FOR PROPOSAL (RFP): The solicitation document that describes the qualification requirements, performance specifications, time frames, and other requirements and asks bidders to describe how they would accomplish the services and at what billable rates.

RFP SECTION: This refers to all subordinate portions of each RFP chapter beginning with the same whole number.

SENIOR HEALTH CARE ACTUARY: This is a full professional level position. The individual must possess an associateship or fellowship in the Society of Actuaries or the Casualty Actuarial Society, and membership in the American Academy of Actuaries. The individual will be responsible for supervising or assuming lead responsibilities over actuarial statisticians and journey/professional level actuaries, and/or acts as a consultant or lead on the most complex and sensitive program issues. The Senior Health Care Actuary must be an expert in health care benefits, preferably in the Medicaid program, and has demonstrated success in managing a consulting unit or sizable client team; provides actuarial opinions and prepares statements, reports, and valuations of actuarial and statistical data relating to health care; may act as a manager or lead over non-actuarial personnel; and prepares memoranda of proposed actions and recommendations based on actuarial applications and conclusions. The individual must have knowledge of managed care principles, and financial structures of various types of managed care companies.

SCOPE OF WORK: Work activities, actions to be performed, deliverables to be supplied, methods and approaches to be used, and expected objectives and outcomes to be achieved under a contractual agreement.

SUBCONTRACT: A formal agreement entered into by the Contractor with any other organization(s) or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligation to the Department under the terms of this contract.

SUBCONTRACTOR: Any and all corporations, partnerships, agents, and/or individuals retained by the Contractor (with prior written approval from the State) to perform services under this RFP, regardless of the amount, duration, or scope of the services provided, and regardless of whether identified in the Contractor's proposal in response to the RFP or subsequently retained during the contract term.

TECHNICAL PROPOSAL: The term used synonymously with the RFP response. A potential Contractor's presentation of proposed activities and/or actions, including recommended approaches or methods to solve or meet a service need, submitted in response to the RFP issued by the State.

TITLE XVIII: That portion of the Social Security Act that authorizes the Medicare program.

TITLE XIX: The Title of the Social Security Act that enacted Medicaid in 1965. Synonymous with the term Medicaid.

TITLE 22: Title 22, Division 3, California Code of Regulations, contains the rules and regulations governing the Medi-Cal program. These regulations define and clarify the provisions of the State statute, primarily the Welfare and Institutions Code.

TURNOVER PERIOD: Prior to the termination or expiration of this Contract and upon request by DHS, the Contractor shall transfer to the DHS, or a successor contractor, Medi-Cal (managed care and/or fee-for-service) beneficiaries' medical record information, managed care plan data, data analysis and evaluation reports, all appropriate Books and Records as defined in Section 11 of Exhibit E (Additional Provisions), and all databases and files required by this Contract.

WELFARE AND INSTITUTIONS (W&I) CODE: The California code of law that includes the Medi-Cal Act.

Appendix 4
Data Library Index for the
Actuarial Rate Development Project

1.0	Two-Plan Model Rate Manual:	
1.1	Rate Period 1998-99	Hard Copy
1.2	Rate Period 1999-00	Hard Copy
1.3	Rate Period 2000-01	Hard Copy
1.4	Rate Period 2001-02	Hard Copy
1.5	Rate Period 2002-03	Hard Copy
1.6	Rate Period 2003-04	Hard Copy
2.0	Two-Plan Model Rate Worksheets for Rate Period 2003-04 (primary contract only)	Hard Copy
3.0	Two-Plan Model Contract Boilerplate	
3.1	Commercial Plan Contract	Hard Copy/CD
3.2	Local Initiative Contract	Hard Copy/CD
3.3	Hyde Contract	Hard Copy/CD
4.0	County Organized Health System Contracts[α]	
4.1	CalOPTIMA (Contract and Amendments 1–6)	Hard Copy
4.2	Central Coast Alliance for Health (Contract and Amendments 1–6)	Hard Copy
4.3	Partnership HealthPlan of California (Contract and Amendments 1-7)	Hard Copy
4.4	Health Plan of San Mateo (Contract and Amendments 1-7)	Hard Copy
4.5	Santa Barbara Regional Health Authority (Contract and Amend 1-3)	Hard Copy
5.0	Examples of Sacramento Geographic Managed Care and San Diego Geographic Managed Care contracts.[α]	
5.1	Blue Cross of California (Sacramento County) (Contract and Amendments 1-3)	Hard Copy
5.2	Kaiser Foundation Health Plan (Sacramento County) (Contract and Amendments 1-4)	Hard Copy
5.3	Western Health Advantage (Sacramento County) (Contract and Amendments 1-2)	Hard Copy
5.4	Blue Cross of California (San Diego County) (Contract and Amendments 1-3)	Hard Copy
6.0	Prepaid Health Plan contract	Hard Copy
7.0	Primary Care and Case Management (PCCM) Contract	Hard Copy
8.0	PCCM Savings Sharing Manual	Hard Copy
9.0	Expanding Medi-Cal Managed Care (also known as the Strategic Plan)	Hard Copy

[α] In accordance with Government Code, Section 6254(q), these contracts and amendments are open for inspection one year after the contract is fully executed; therefore, a contract/amendment is not included if executed after April 1, 2003. The rates of payment have been blocked out until the contract/amendment has been open for inspection for three years (April 1, 2000).

10.0	Aid Code definitions	Hard Copy/CD
11.0	Federal Register/Volume 67, No. 115/Friday June 14, 2002/Rules and Regulations (Implementation of Medicaid managed care requirements of the Balanced Budget Act of 1997)	Hard Copy